

PART I

Child's Medical & Social Information

(to be completed by parent/guardian/care-giver)

1. Name _____ SSN _____
Age _____ Sex _____ MEDS PN _____ Parish _____
2. Name of person providing information _____
Relationship to child _____
3. Who else lives in the home with the child? _____

4. Describe this child's disability and how it affects his or her ability to do the things most children do.

5. When did the disability begin? _____
6. Is the child in school? ☐ Yes ☐ No If **Yes**, please give the following information.
Name of school: _____
School address: _____
School Telephone: _____ Teacher's Name: _____
Grade Level: _____ ☐ Regular Classes ☐ Special Education ☐ Resource Classes
7. Does this child have any special problems in school? ☐ Yes ☐ No If **Yes**, please describe.

8. If this child is school-age but is **not** in school, please explain why he or she is not in school.

9. Please describe the way this child spends an average day from the time he or she gets up until bedtime. _____

10. List any activities in which the child participates (sports, hobbies, school activities, scouting, clubs, etc.) and how often he/she participates. _____

11. Have there been any changes in the child's activities or behavior since his or her condition began?
☐ Yes ☐ No If **Yes**, please explain. _____

12. Does the child help with any household chores? ☐ Yes ☐ No If **Yes**, what are the chores?

How often are they done? _____
How well are they done? _____
How much supervision is needed? _____
13. How does the child behave with adults (parents, other family members, teachers, neighbors)? Please give examples. _____

14. Does the child's condition cause pain or discomfort? ☐ Yes ☐ No If **Yes**, how does this affect his/her daily activities? _____

15. Where does the child receive medical treatment?
☐ Mental Health Clinic ☐ Private Physician ☐ Clinic ☐ Hospital ☐ Other Source
16. How often does the child visit the doctor or receive medical treatment? _____

17. What medical records are available (for the 12 months preceding application) to document the child's disability? _____

18. Has the child undergone medical tests by a medical specialist or anyone else not listed above?
☐ Yes ☐ No If **Yes**, by whom or where, what test, and approximately what date? _____

19. Is the child taking medication? ☐ Yes ☐ No If **Yes**, please complete the following.

Name of Medication	Prescription		Dosage/How Often Taken
	Yes	No	

20. How does this medication affect the child? _____

21. If there is anyone else (friends, relatives, counselor) who can provide information about the child's condition, please provide his/her name, phone number and relationship to the child.

Name	Phone Number	Relationship

22. Has this child applied for Supplemental Security Income (SSI) benefits? ☐ Yes ☐ No

If **Yes**, when? _____

What is the status of the application? ☐ Approved ☐ Pending ☐ Appealed ☐ Denied ☐ Terminated

If denied OR terminated, when? _____ Why? _____

23. Tell us any other information that you think we need to know about this child. _____

Signature _____ Date _____

Phone _____

PART II

Certification Information

(to be completed by Medicaid office staff)

1. Application Date: _____ OR Redetermination Date: _____
2. Is retroactive medical eligibility being requested? ☐ Yes ☐ No
If **Yes**, for which months? _____
3. What period of eligibility is being requested? _____

4. Is this applicant/recipient an ineligible or illegal alien? ☐ Yes ☐ No
5. Specify the Medicaid program for which a disability decision is being requested:
☐ Affected Child
☐ MNP
☐ LTC/Waiver
☐ Other _____

Signature of Agency Representative

Date

Signature of Supervisor

Date

Telephone Number of Supervisor